Appendix

Appendix 1
CMS 1500 Claim Form Completion Instructions for Disposable Medical Supplies

Use the following claim form completion instructions, ***not*** the claim form's printed descriptions, to avoid denial or inaccurate claim payment. Do not include attachments unless instructed to do so. Complete the elements listed below as appropriate.

Note: Medicaid providers should ***always*** verify recipient eligibility before delivering services.

Element 1 — Program Block/Claim Sort Indicator

Enter claim sort indicator "D" in the Medicaid check box for the service billed.

Element 1a — Insured's I.D. Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 2 — Patient's Name

Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Mother/Baby Claims

A provider may submit claims for an infant if the infant is 10 days old or less on the date of service (DOS) and the mother of the infant is a Medicaid recipient. To submit a claim for an infant using the mother's Medicaid identification number, enter the following:

Element 1a: Enter the mother's 10-digit Medicaid identification number.
Element 2: Enter the mother's last name followed by "newborn."
Element 3: Enter the ***infant's*** date of birth.
Element 4: Enter the mother's name followed by "mom" in parentheses.
Element 21: Indicate the secondary or lesser diagnosis code "M11" in fields 2, 3, or 4.

Element 3 — Patient's Birth Date, Patient's Sex

Enter the recipient's birth date in MM/DD/YY format (e.g., June 30, 1975, would be 06/30/75) or in MM/DD/YYYY format (e.g., June 30, 1975, would be 06/30/1975). Specify if the recipient is male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

Enter the complete address of the recipient's place of residence, if known.

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name

Third-party insurance (commercial insurance coverage) must be billed prior to billing Wisconsin Medicaid, unless the service does not require third-party billing as determined by Wisconsin Medicaid.

- When the recipient has dental ("DEN") insurance only or has no commercial insurance, leave Element 9 blank.
- When the recipient has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), TriCare ("CHA"), or some other ("OTH") commercial insurance, ***and*** the service requires third-party billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of

the following three other insurance (OI) explanation codes ***must*** be indicated in the ***first*** box of Element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID by health insurance. In Element 29 of this claim form, indicate the amount paid by health insurance to the provider or to the insured.
OI-D	DENIED by health insurance following submission of a correct and complete claim, ***or*** payment was applied towards the coinsurance and deductible. Do ***not*** use this code unless the claim was actually billed to the health insurer.
OI-Y	YES, the recipient has health insurance, but it was not billed for reasons including, but not limited to: √ Recipient denied coverage or will not cooperate. √ The provider knows the service in question is not covered by the carrier. √ Health insurance failed to respond to initial and follow-up claims. √ Benefits not assignable or cannot get assignment.

- When the recipient is a member of a commercial HMO, one of the following must be indicated, ***if applicable****:*

Code	Description
OI-P	PAID by HMO. The amount paid is indicated on the claim.
OI-H	HMO does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may not use OI-H if the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Wisconsin Medicaid for services which are included in the capitation payment.

Element 10 — Is Patient's Condition Related to (not required)

Element 11 — Insured's Policy, Group, or FECA Number

Use the ***first*** box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Bill Medicare before billing Wisconsin Medicaid.

Element 11 should be left blank when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- The recipient's Wisconsin Medicaid file shows he or she does not have any Medicare coverage for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A. Services related to a diagnosis of chronic renal failure are the only exceptions.
- The ***nonphysician*** provider's Wisconsin Medicaid file shows he or she is not Medicare certified. (This does not apply to physicians because Medicare will retroactively certify physicians for the date and the service provided if they held a valid license when the service was performed.)
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

If none of the previous statements are true, a Medicare disclaimer code is necessary.

Appendix 1
(Continued)

The following Medicare disclaimer codes can be used when appropriate:

Code	Description
M-1	**Medicare benefits exhausted.** This code can be used when Medicare has denied the charges because the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use the M-1 disclaimer in these two instances only: *For Medicare Part A* (all three criteria must be met): • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. • The recipient is eligible for Medicare Part A. • The service provided is covered by Medicare Part A but is not payable due to benefits being exhausted. *For Medicare Part B* (all three criteria must be met): • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. • The recipient is eligible for Medicare Part B. • The service provided is covered by Medicare Part B but is not payable due to benefits being exhausted.
M-5	**Provider is not Medicare certified.** This code can be used when providers are identified in Wisconsin Medicaid files as being Medicare certified, but are billing for DOS before or after their Medicare certification effective dates. Use M-5 in these two instances only: *For Medicare Part A* (all three criteria must be met): • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A but not for the date the service was provided. • The recipient is eligible for Medicare Part A. • The procedure provided is covered by Medicare Part A. *For Medicare Part B* (all three criteria must be met): • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B but not for the date the service was provided. • The recipient is eligible for Medicare Part B. • The procedure provided is covered by Medicare Part B. *Note:* The following providers are required to be certified by Medicare if they intend to provide a Medicare-covered service to a dual entitlee: • Home care agencies. • Medical equipment vendors. • Pharmacies. • Physicians.

M-6 **Recipient not Medicare eligible.** This code can be used when Medicare denies payment for services related to ***chronic renal failure*** (diagnosis code "585") because the recipient is not eligible for Medicare. Medicare must be billed first, even when the recipient is identified in Wisconsin Medicaid files as not eligible for Medicare. Use the M-6 disclaimer code in these two instances only:

For Medicare Part A (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- Medicare denies the recipient eligibility.
- The service is related to chronic renal failure.

For Medicare Part B (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- Medicare denies the recipient eligibility.
- The service is related to chronic renal failure.

M-7 **Medicare disallowed or denied payment.** This code applies when Medicare denies the claim for reasons related to policy, not billing errors. Use M-7 in these two instances only:

For Medicare Part A (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, etc.

For Medicare Part B (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, etc.

M-8 **Noncovered Medicare service.** This code can be used when Medicare was not billed because the service, under certain circumstances related to the recipient's diagnosis, is not covered. Use M-8 in these two instances only:

For Medicare Part A (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is usually covered by Medicare Part A but not under certain circumstances related to the recipient's diagnosis.

For Medicare Part B (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is usually covered by Medicare Part B but not under certain circumstances related to the recipient's diagnosis.

Elements 12 and 13 — Authorized Person's Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source

Enter the referring or prescribing physician's name and his or her six-character Universal Provider Identification Number (UPIN). If the UPIN is not available, enter the Medicaid provider number or license number of the referring provider. (This is not required on claims for hearing aid batteries.)

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use (not required)

Element 20 — Outside Lab? (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

Enter the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. The diagnosis description is not required.

Wisconsin Medicaid denies claims without the appropriate ICD-9-CM diagnosis code. One source to order the complete ICD-9-CM code book is:

St Anthony Publishing Inc
PO Box 96561
Washington DC 20090
(800) 632-0123

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number

Enter the seven-digit prior authorization (PA) number from the approved PA request. Services authorized under multiple PAs must be billed on separate claim forms with their respective PA numbers.

Element 24A — Date(s) of Service

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one DOS, enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for two, three, or four DOS on the same detail line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the "From" field, and subsequent DOS in the "To" field by listing ***only*** the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four DOS per line if:

- All DOS are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.

- All procedures have the same type of service (TOS) code.
- All procedures have the same place of service (POS) code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge ***per detail line*** in Element 24F.)
- The number of services performed on each DOS is identical.
- All procedures have the same HealthCheck or family planning indicator.
- All procedures have the same emergency indicator.

Element 24B — Place of Service

Enter the appropriate Medicaid single-digit POS code for each service.

Code	Description
0	Other
3	Office
4	Home
7	Nursing Facility
8	Skilled Nursing Facility

Element 24C — Type of Service

Enter a "9" for the TOS code for each service *except* for exceptional supplies. When submitting a claim for exceptional supplies, enter a "P" for purchased items or an "R" for rented items.

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character procedure code as listed in the Disposable Medical Supplies (DMS) Index. Claims received without an appropriate procedure code are denied by Wisconsin Medicaid. All DMS procedure codes must include the correct DMS modifier. Refer to the DMS Index for a list of Wisconsin Medicaid-allowable procedure codes.

Modifiers

Enter the appropriate two-character modifier in the "Modifier" column of Element 24D as indicated in the DMS Index. Please note that Wisconsin Medicaid has ***not*** adopted all *Current Procedural Terminology*, Health Care Procedure Coding System, formerly known as "HCFA Common Procedure Coding System," or Medicare modifiers.

Element 24E — Diagnosis Code

Enter the number (1, 2, 3, or 4) that corresponds to the appropriate diagnosis code listed in Element 21.

Element 24F — Charges

Enter the total charge for each line item.

Element 24G — Days or Units

Enter the appropriate number of units, time units, qualifying circumstance units, or other services billed for each line item. Always use a decimal (e.g., 2.0 units).

Element 24H — EPSDT/Family Planning

Enter an "H" for each procedure that was performed as a result of a HealthCheck referral. Enter an "F" for each family planning procedure. Enter a "B" if ***both*** HealthCheck and family planning services were provided. If HealthCheck or family planning do not apply, leave this element blank.

Element 24I — EMG

Enter an "E" for ***each*** procedure performed as an emergency, regardless of the POS. If the procedure is not an emergency, leave this element blank.

Element 24J — COB (not required)

Element 24K — Reserved for Local Use

Enter the eight-digit, Medicaid provider number of the performing provider ***for each procedure***, if the billing provider indicated in Element 33 belongs to a physician clinic or group.

Any other information entered in this element may cause claim denial.

Element 25 — Federal Tax I.D. Number (not required)

Element 26 — Patient's Account No.

Optional — provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the Remittance and Status Report.

Element 27 — Accept Assignment (not required)

Element 28 — Total Charge

Enter the total charges for this claim.

Element 29 — Amount Paid

Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in Element 29, "OI-P" must be indicated in Element 9.) Do ***not*** enter Medicare-paid amounts in this field.

Element 30 — Balance Due

Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28.

Element 31 — Signature of Physician or Supplier

The provider or the authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format.

Note: The signature may be a computer-printed or typed name and date, or a signature stamp with the date.

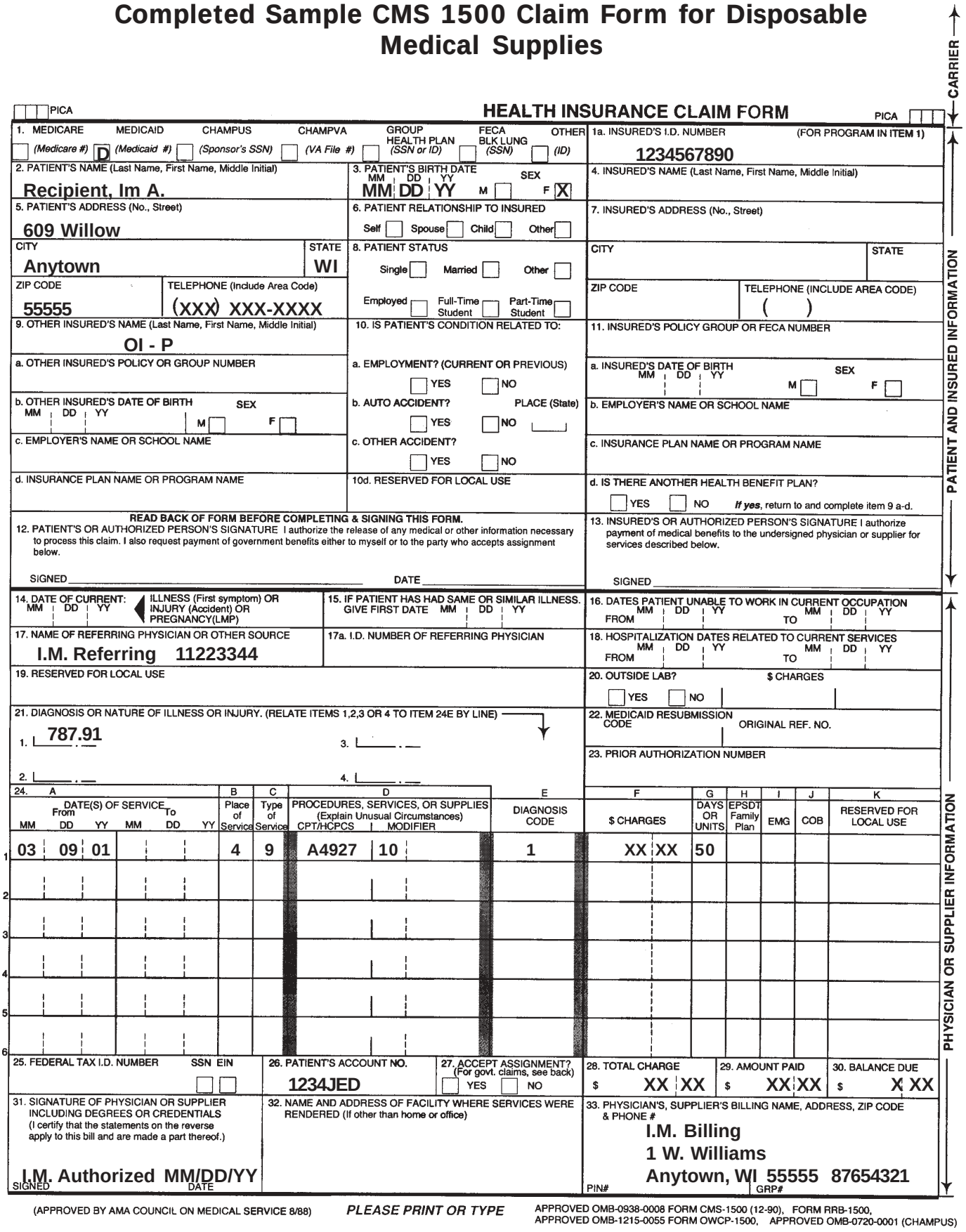
Element 32 — Name and Address of Facility Where Services Were Rendered (not required)

Element 33 — Physician's, Supplier's Billing Name, Address, ZIP Code, and Phone

Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

Appendix 2

Completed Sample CMS 1500 Claim Form for Disposable Medical Supplies



PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) D | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY | SEX M | F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown | STATE: WI

8. PATIENT STATUS: Single | Married | Other

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed | Full-Time Student | Part-Time Student

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI - P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 11223344

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 787.91 3. 2. 4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	03 09 01	4	9	A4927	10	1	XX XX	50				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN | EIN

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $ XX XX

29. AMOUNT PAID $ XX XX

30. BALANCE DUE $ X XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED I.M. Authorized DATE MM/DD/YY

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 87654321

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Appendix

Appendix 3
Description of Exceptional Supplies

General Information

Most disposable medical supplies (DMS) and durable medical equipment (DME) are included in the daily rate for nursing homes and are not separately reimbursable. However, providers may receive reimbursement for certain DMS and DME provided to nursing home recipients whose medical conditions make them eligible for exceptional supplies. The exceptional supply procedure code allows Wisconsin Medicaid to separately reimburse certain supplies and equipment that are usually included in the nursing home daily rate. Recipients who have exceptional supply needs may either:

- Be ventilator dependent.
- Have a tracheostomy that requires extensive care at least twice in an eight-hour period of time.

Covered items are limited to those supplies and equipment necessary to treat the above conditions. Wisconsin Medicaid will not cover unnecessary, unreasonable, or inappropriate items as determined by Wisconsin Medicaid nurse consultants. Providers are required to document the need for exceptional supplies in the physician's orders, progress notes, and treatment sheets.

Prior Authorization

For Wisconsin Medicaid to consider reimbursement, providers are required to obtain prior authorization (PA) before dispensing exceptional supplies.

Submit requests for PA on the Prior Authorization Request Form (PA/RF) and the Prior Authorization Durable Medical Equipment Attachment (PA/DMEA). Providers are required to use the procedure code "W6890" on the PA/RF. Exceptional supplies for nursing home recipients cannot be reimbursed under other procedure codes. Providers should use the procedure code for both purchased and rented exceptional supplies. Therefore, group all needed supplies under the specified procedure code.

Use type of service (TOS) "P" for purchased items or "R" for rented items in Element 17 of the PA/RF.

Providers are also required to submit the following with the PA/RF:

- Documentation indicating that the recipient is ventilator dependent or has a tracheostomy that requires exceptional supplies.
- A physician's prescription detailing the equipment and/or quantity of needed supplies. Wisconsin Medicaid will not consider a PRN (from the Latin term *pro re nata*, meaning "as needed") prescription as a substitute for a physician prescription.
- Treatment sheets or a medical checklist documenting the actual use and frequency of use of the supplies and equipment.
- A record of the exact quantity of supplies used in the time period preceding the PA request.

Providers are required to include the "per unit" charge for each supply item, the frequency of use, and the estimated monthly quantity needed by the recipient. The total estimated monthly charge for all supplies must be indicated in Element 21 of the PA/RF.

If using attachments, please write the PA number on each page, in case they are separated from the PA/RF during processing.

Billing and Reimbursement

Providers should bill for prior authorized exceptional supplies on the CMS 1500 claim form.

If exceptional supplies are used on a daily basis, providers may bill using the beginning date of service (DOS) in the "From" column and the last DOS for each month in the "To" column in Element 24A. The quantity billed must equal the number of days within the range approved on the PA/RF. Use TOS "P" for purchased items and "R" for rented items in Element 24C.

Wisconsin Medicaid authorizes reimbursement for exceptional supplies at an average daily maximum dollar amount, based on the average daily use. The average daily maximum dollar amount is figured by multiplying the frequency of use per 30-day period by the reimbursement rate for each item, adding all of the sums, and dividing by 30. Wisconsin Medicaid will not reimburse for exceptional supplies at any rate higher than the average daily maximum dollar amount.

If a recipient's need for exceptional supplies declines, resulting in the usage of fewer supplies, the average maximum amount charged to Wisconsin Medicaid should decrease accordingly.

Appendix 4
Key to Reading the Disposable Medical Supplies Index

The Disposable Medical Supplies (DMS) Index lists the items covered by Wisconsin Medicaid, the maximum allowable fee for each item, and the limitations applicable to each code. The DMS Index key on the reverse side of this page provides helpful information for reading the DMS Index.

Providers may access an interactive, online version of the DMS Index on Wisconsin Medicaid's Web site at *www.dhfs.state.wi.us/medicaid/*.

Providers may also:

- Download an electronic version from Wisconsin Medicaid's Web site at *www.dhfs.state.wi.us/medicaid/*.
- Purchase additional copies of the DMS Index by calling Provider Services at (800) 947-9627 or (608) 221-9883, or by writing to:

  Wisconsin Medicaid
  Provider Maintenance
  6406 Bridge Rd
  Madison WI 53784-0006

Contact Provider Services for the cost of the maximum allowable fee schedule.

KEY TO READING THE DISPOSABLE MEDICAL SUPPLIES INDEX MAXIMUM ALLOWABLE FEE SCHEDULE

CODE: Five-digit alphanumeric Health Care Procedure Coding System (HCPCS), formerly known as "HCFA Common Procedure Coding System," National Level II codes developed by the federal Centers for Medicare and Medicaid Services (CMS), formerly HCFA, or Wisconsin Medicaid-assigned local procedure codes that identify the Disposable Medical Supplies (DMS).

MODIFIER: Modifiers used by Wisconsin Medicaid to indicate additional entries of procedure codes associated to the HCPCS and Wisconsin Medicaid-assigned base codes.

Y — Indicates modifiers specified must always be used when billing for the procedure code.
N — Indicates modifiers are not required when billing for the procedure code but, if listed, may be used if the modifier indicates a more accurate definition of the supply.

IN NH RATE: YES — Indicates that the item is included in the nursing home daily rate and is not separately reimbursable for Wisconsin Medicaid nursing home residents.
NO — Indicates this item is not included in the nursing home daily rate and is separately reimbursable for Wisconsin Medicaid nursing home recipients.

IN HC RATE: YES — Indicates that the item is included in the home care rate and is not separately reimbursable for Wisconsin Medicaid home care recipients. Home care services include covered services provided by home health agencies, personal care agencies, and nurses in independent practice.
NO — Indicates this item is not included in the home care rate and is separately reimbursable for Wisconsin Medicaid home care recipients.

DESCRIPTION: Base HCPCS or Wisconsin Medicaid-assigned local procedure code. The description that appears in the first row of each procedure code is the description that will appear on Remittance and Status (R/S) Reports, regardless of the modifier used. Providers will need to use the DMS Index/Maximum Allowable Fee Schedule with the R/S Report to verify Wisconsin Medicaid's maximum allowable fee payments.

Descriptions may also indicate quantities of each, package, and per box, which is considered one unit. For example, a box may contain multiple items. If "per box of 100" is indicated, the quantity or unit is equal to one (1).

MAX FEE: Maximum allowable fee for each procedure code and modifier.

MAX QTY/MO: Quantity allowed per recipient per calendar month (January, February, March, etc.) unless a different time period is indicated.

CHANGE: Current DMS Index revisions.
C — Indicates changes.
N — Indicates new information.

Appendix 5
Prior Authorization Request Form (PA/RF) Instructions for Disposable Medical Supplies

Element 1 — Processing Type

Enter the appropriate three-digit processing type from the list below. The "processing type" is a three-digit code used to identify a category of service requested.

132 — Disposable medical supplies (DMS)
139 — Exceptional supplies

Element 2 — Recipient's Medicaid Identification Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 3 — Recipient's Name

Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 4 — Recipient's Address

Enter the complete address (street, city, state, and ZIP code) of the recipient's place of residence. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

Element 5 — Recipient's Date of Birth

Enter the recipient's date of birth in MM/DD/YYYY format (e.g., June 30, 1975, would be 06/30/1975).

Element 6 — Recipient's Sex

Enter an "X" to specify male or female.

Element 7 — Billing Provider's Name, Address, and ZIP Code

Enter the billing provider's name and complete address (street, city, state, and ZIP code). ***No other information should be entered in this element since it also serves as a return mailing label.***

Element 8 — Billing Provider's Telephone Number

Enter the billing provider's telephone number, including the area code of the office, clinic, facility, or place of business.

Element 9 — Billing Provider's Medicaid Number

Enter the provider's eight-digit Medicaid provider number.

Element 10 — Dx: Primary

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested for the recipient.

Note: Medical vendors and individual medical suppliers need only provide a written description.

Element 11 — Dx: Secondary

Enter the appropriate ICD-9-CM diagnosis code and description additionally descriptive of the recipient's clinical condition.

Note: Medical vendors and individual medical suppliers need only provide a written description.

Element 12 — Start Date of Spell of Illness (not required)

Element 13 — First Date Rx (not required)

Element 14 — Procedure Code(s)

Enter the appropriate Wisconsin Medicaid-assigned five-digit procedure code for each service/procedure/item requested.

Element 15 — MOD

Enter the modifier corresponding to the procedure code (if a modifier is required by Wisconsin Medicaid policy and the coding structure used) for each service/procedure/item requested.

Element 16 — POS

Enter the appropriate Medicaid single-digit place of service code designating where the requested service/procedure/item would be provided/performed/dispensed.

Code	Description
0	Other
3	Office
4	Home
7	Nursing Facility
8	Skilled Nursing Facility

Element 17 — TOS

Enter the appropriate type of service code for each service/procedure/item requested.

Code	Description
9	Disposable Medical Supplies (DMS) — Health Care Procedure Coding System (HCPCS) codes, formerly known as "HCFA Common Procedure Coding System"
P	Purchase New Durable Medical Equipment (DME) (for exceptional supplies only)
R	DME Rental (for exceptional supplies only)

Element 18 — Description of Service

Enter a written description corresponding to the appropriate five-digit procedure code for each service/procedure/item requested.

Element 19 — Quantity of Service Requested

Enter the quantity requested for each service/procedure/item requested.

Element 20 — Charges

Enter your usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

Note: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to the Department of Health and Family Service's *Terms of Reimbursement.*

Element 21 — Total Charge

Enter the anticipated total charge for this request.

Element 22 — Billing Claim Payment Clarification Statement

An approved authorization does not guarantee payment. Reimbursement is contingent upon the recipient's and provider's eligibility at the time the service is provided and the completeness of the claim information. Payment is not made for services initiated prior to approval or after authorization expiration. Reimbursement is in accordance with Medicaid payment methodology and policy. If the recipient is enrolled in a managed care program at the time a prior authorized service is provided, Wisconsin Medicaid reimbursement is only allowed if the service is not covered by the managed care program.

Element 23 — Date

Enter the month, day, and year (in MM/DD/YYYY format) the Prior Authorization Request Form (PA/RF) was completed and signed.

Element 24 — Requesting Provider's Signature

The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element. Providers are required to enter the requested start and end dates after the requesting provider's signature.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER — THIS SPACE IS USED BY THE WISCONSIN MEDICAID CONSULTANT(S) AND ANALYST(S).

Appendix 6
Completed Sample Prior Authorization Request Form (PA/RF)

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1223334

1 PROCESSING TYPE: 132

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Ima A.
4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 55555
5 DATE OF BIRTH: MM/DD/YYYY
6 SEX: M [ ] F [X]
8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: I.M. Provider, 1 W. Williams, Anytown, WI 55555
9 BILLING PROVIDER NO.: 12345678
10 DX: PRIMARY: 250.01 Diabetes
11 DX: SECONDARY: 595.9 Cystitis
12 START DATE OF SOI:
13 FIRST DATE RX:

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
A4253		4	9	Blood glucose test strips	3	XXX.XX
A4259		4	9	Lancets	2	XXX.XX
				TOTAL CHARGE	21	XXX.XX

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YYYY (DATE)
24 I.M. Provider (REQUESTING PROVIDER SIGNATURE)
start date: 01-01-01
end date: 03-31-01

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:
[ ] APPROVED
GRANT DATE
EXPIRATION DATE
PROCEDURE(S) AUTHORIZED
QUANTITY AUTHORIZED
[ ] MODIFIED – REASON:
[ ] DENIED – REASON:
[ ] RETURN – REASON:

DATE
CONSULTANT/ANALYST SIGNATURE

482-120

Appendix 7
Completed Sample Prior Authorization Request Form (PA/RF), Prior Approval Granted

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 1223334

1 PROCESSING TYPE: 132

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890	4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 55555
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Ima A.	
5 DATE OF BIRTH: MM/DD/YYYY	6 SEX: M [ ] F [X]
	8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: I.M. Provider, 1 W. Williams, Anytown, WI 55555	9 BILLING PROVIDER NO.: 12345678
	10 DX: PRIMARY: 250.01 Diabetes
	11 DX: SECONDARY: 595.9 Cystitis
	12 START DATE OF SOI: / 13 FIRST DATE RX:

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
A4253		4	9	Blood glucose test strips	3	XXX.XX
A4259		4	9	Lancets	2	XXX.XX
					TOTAL CHARGE	21 XXX.XX

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YYYY (DATE) 24 I.M. Provider (REQUESTING PROVIDER SIGNATURE)

start date: 01-01-01
end date: 03-31-01

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

[X] APPROVED

01-01-01 GRANT DATE

03-31-01 EXPIRATION DATE

PROCEDURE(S) AUTHORIZED	QUANTITY AUTHORIZED
A4253	9
A4259	5

[ ] MODIFIED – REASON:

[ ] DENIED – REASON:

[ ] RETURN – REASON:

12/27/00 (DATE)

J.M. Nurse Consultant (CONSULTANT/ANALYST SIGNATURE)

482-120

Appendix 8

Completed Sample Prior Authorization Request Form (PA/RF) for Exceptional Supplies

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 1223334

1 PROCESSING TYPE: 139

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Ima A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 55555

5 DATE OF BIRTH: MM/DD/YYYY

6 SEX: M [ ] F [X]

8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
I.M. Provider
1 W. Williams
Anytown, WI 55555

9 BILLING PROVIDER NO.: 12345678

10 DX: PRIMARY: 518.81 Resp. Failure

11 DX: SECONDARY: V55.0 Tracheostomy

12 START DATE OF SOI:

13 FIRST DATE RX:

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W6890		8	P	Trach care kit BID	60	XXX.XX
W6890		8	P	Trach suction catheter/every shift	90	XXX.XX
W6890		8	P	Trach tie/secure every 3 days	10	XXX.XX
W6890		8	R	Compressor	30	XXX.XX
					TOTAL CHARGE	21 XXX.XX

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YYYY (DATE)

24 I.M. Provider (REQUESTING PROVIDER SIGNATURE)

start date: 01-01-01
end date: 06-30-01

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

[ ] APPROVED

GRANT DATE

EXPIRATION DATE

PROCEDURE(S) AUTHORIZED

QUANTITY AUTHORIZED

[ ] MODIFIED – REASON:

[ ] DENIED – REASON:

[ ] RETURN – REASON:

DATE

CONSULTANT/ANALYST SIGNATURE

482-120

Appendix

Appendix 9

Completed Sample Prior Authorization Request Form (PA/RF) for Exceptional Supplies, Prior Approval Granted

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1223334

1 PROCESSING TYPE: 139

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Ima A.
4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 55555
5 DATE OF BIRTH: MM/DD/YYYY
6 SEX: M [ ] F [X]
8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: I.M. Provider, 1 W. Williams, Anytown, WI 55555
9 BILLING PROVIDER NO.: 12345678
10 DX: PRIMARY: 518.81 Resp. Failure
11 DX: SECONDARY: V55.0 Tracheostomy
12 START DATE OF SOI:
13 FIRST DATE RX:

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W6890		8	P	Trach care kit BID	60	XXX.XX
W6890		8	P	Trach suction catheter/every shift	90	XXX.XX
W6890		8	P	Trach tie/secure every 3 days	10	XXX.XX
W6890		8	R	Compressor	30	XXX.XX
					TOTAL CHARGE	21 XXX.XX

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YYYY (DATE)
24 I.M. Provider (REQUESTING PROVIDER SIGNATURE)
start date: 01-01-01
end date: 06-30-01

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:
[X] APPROVED
01-01-01 GRANT DATE
06-30-01 EXPIRATION DATE

PROCEDURE(S) AUTHORIZED — QUANTITY AUTHORIZED

W6890 (P)
Average daily max $XX.XX 181 days

W6890 (R)
Average daily max $XX.XX 181 days

[ ] MODIFIED – REASON:
[ ] DENIED – REASON:
[ ] RETURN – REASON:

12/27/00 (DATE)
J.M. Nurse Consultant (CONSULTANT/ANALYST SIGNATURE)

482-120

Appendix

Appendix 10
Prior Authorization Durable Medical Equipment Attachment (PA/DMEA) Completion Instructions

The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted by providers when requesting prior authorization (PA). Carefully complete this attachment form, attach it to the Prior Authorization Request Form (PA/RF) and submit it to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

Recipient Information:

Element 1 — Last Name

Enter the recipient's last name. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — First Name

Enter the recipient's first name. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 3 — Middle Initial

Enter the recipient's middle initial. Use the EVS to obtain the correct initial of the recipient's name. If the initial on the Medicaid identification card and the EVS do not match, use the initial from the EVS.

Element 4 — Medical Assistance ID Number

Enter the recipient's ten-digit Medicaid number. Do not enter any other numbers or letters.

Element 5 — Age

Enter the age of the recipient in numerical form (i.e., 45, 60, 21).

Provider Information:

Element 6 — Prescribing Physician's Name

Enter the name of the prescribing physician in this element.

Element 7 — Prescribing Physician's Medical Assistance Provider Number

Enter the eight-digit Medicaid provider number of the physician prescribing the item(s) of disposable medical supplies (DMS).

Element 8 — Dispensing Provider's Telephone Number

Enter the telephone number, including area code, of the provider *dispensing* the requested DMS.

The remaining portions of this attachment are to be used to document the justification for the requested DMS item(s).

- Complete Elements A through H and J for all requested DMS items. Documentation of current medical necessity, individualized for each recipient, must be demonstrated.
- Attach a photocopy of the physician's prescription to this attachment. The prescription must be signed and dated within six months of receipt by Wisconsin Medicaid.
- Read the PA Statement before dating and signing the attachment.
- The attachment must be dated and signed by the provider requesting/dispensing the supplies.

Appendix 11

Sample Completed Prior Authorization Durable Medical Equipment Attachment (PA/DMEA)

Mail To:
Wisconsin Medicaid
Prior Authorization Unit
Suite 88
6406 Bridge Rd.
Madison, WI 53784-0088

PA/DMEA

PRIOR AUTHORIZATION DURABLE MEDICAL EQUIPMENT ATTACHMENT

1. Complete this form.
2. Attach to PA/RF.
   (Prior Authorization/Request Form)
3. Mail to Wisconsin Medicaid.

RECIPIENT INFORMATION

(1)	(2)	(3)	(4)	(5)
Recipient	Im	A	1234567890	35
LAST NAME	FIRST NAME	MIDDLE INITIAL	MEDICAL ASSISTANCE ID NUMBER	AGE

PROVIDER INFORMATION

(6)	(7)	(8)
I.M. Prescribing	12345678	(XXX) XXX-XXXX
PRESCRIBING PHYSICIAN'S NAME	PRESCRIBING PHYSICIAN'S MEDICAL ASSISTANCE PROVIDER NUMBER	DISPENSING PROVIDER'S TELEPHONE NUMBER

A. Describe the overall physical status of the recipient: (mobility, self-care, strength, coordination)

Is independent in mobility and self cares. Shows adequate and normal strength and coordination.

B. Describe the medical condition of the recipient as it relates to the equipment/item requested — Why does the recipient need this equipment?

Has Type 1 diabetes, was recently in good control with BID testing of blood sugars. Recent bladder infection, currently on antibiotics. Physician ordered additional testing. Increased to 5x's per day.

C. Is the recipient able to operate the equipment/item requested — ☒ Yes ❑ No — if not, who will do this?

Independent

D. Is training provided or required? ❑ Yes ☒ No Explain: **Recipient previously instructed on proper glucometer use. Demonstrates good technique.**

E. State where equipment/item will be used:

☒ Home (Describe type of dwelling and accessibility)

Ranch type, NO accessibility problems.

❑ Nursing Home ❑ School ❑ Office ❑ Job
(Describe type of dwelling and accessibility)

F. Attach an Occupational or Physical Therapy Report if available.
Not applicable.

G. State estimated duration of need:
2-3 months. Once infection resolved will decrease to BID testing.

H. If renewal or continuation of DME Authorization is requested, describe the recipient's
- Current clinical condition
- Progress (improvement; no change, etc.)
- Results
- Recipient's use of equipment/item prescribed

Initial PA request, not applicable.

I. Indicate amount of oxygen to be administered: **Not applicable.**

____ Liters per minute	____ Continuous
____ Hours per day	____ PRN
____ Days per week	____ PaO_2

Attach a photocopy of the Physician's Prescription to this Attachment form. The prescription must be signed and dated within 6 months of receipt by Wisconsin Medicaid.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

J. **MM/DD/YYYY** I.M. Provider

Date — Requesting Provider's Signature

Appendix 12
Prior Authorization Durable Medical Equipment Attachment (PA/DMEA) (for photocopying)

(A copy of the Prior Authorization Durable Medical Equipment Attachment (PA/DMEA) is located on the following pages.)

(This page was intentionally left blank.)

Mail To:

Wisconsin Medicaid
Prior Authorization Unit
Suite 88
6406 Bridge Rd.
Madison, WI 53784-0088

PA/DMEA

PRIOR AUTHORIZATION DURABLE MEDICAL EQUIPMENT ATTACHMENT

1. Complete this form.
2. Attach to PA/RF.
   (Prior Authorization/Request Form)
3. Mail to Wisconsin Medicaid.

RECIPIENT INFORMATION

(1)	(2)	(3)	(4)	(5)
LAST NAME	FIRST NAME	MIDDLE INITIAL	MEDICAL ASSISTANCE ID NUMBER	AGE

PROVIDER INFORMATION

(6)	(7)	(8)
PRESCRIBING PHYSICIAN'S NAME	PRESCRIBING PHYSICIAN'S MEDICAL ASSISTANCE PROVIDER NUMBER	DISPENSING PROVIDER'S TELEPHONE NUMBER

A. Describe the overall physical status of the recipient: (mobility, self-care, strength, coordination)

B. Describe the medical condition of the recipient as it relates to the equipment/item requested — Why does the recipient need this equipment?

C. Is the recipient able to operate the equipment/item requested — ☐ Yes ☐ No — if not, who will do this?

D. Is training provided or required? ☐ Yes ☐ No Explain:

E. State where equipment/item will be used:

☐ Home (Describe type of dwelling and accessibility)

☐ Nursing Home ☐ School ☐ Office ☐ Job
(Describe type of dwelling and accessibility)

F. Attach an Occupational or Physical Therapy Report if available.

G. State estimated duration of need:

H. If renewal or continuation of DME Authorization is requested, describe the recipient's
- Current clinical condition
- Progress (improvement; no change, etc.)
- Results
- Recipient's use of equipment/item prescribed

I. Indicate amount of oxygen to be administered:

____ Liters per minute	____ Continuous
____ Hours per day	____ PRN
____ Days per week	____ PaO_2

Attach a photocopy of the Physician's Prescription to this Attachment form. The prescription must be signed and dated within 6 months of receipt by Wisconsin Medicaid.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

J. _____ _____
Date Requesting Provider's Signature

Reset Form